Short Term Disability

APPLICATION FOR GROUP INSURANCE

TRANSAMERICA ASSURANCE COMPANY
Home Office: Kansas City, Missouri
Administrative Office: 1020 West 4th Street, P. O. Box 8063, Little Rock, AR 72203
Toll Free Telephone No: 1-800-322-0426

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐	Birthdate	Age	Ht.	Wt.	Social Security Number
Applicant _____ (First Middle Last)	/ /				/ /

Home Address _____ (No. Street City State Zip) Home Phone # ( ) -

Employer Name **Williamson County Government and BOE** Phone # ( ) -

Occupation _____ Salary $_____ ☒ Annually ☐ Weekly ☐ Monthly

Benefits Applied For:

	Plan	Amt	Employee Prem	Employer Prem	Total Prem
Disability Income					
☒ Non Occ					
☐ _____					
Optional Coverages					
☐ _____					
☐ _____					
☐ _____					
☐ _____					
☐ _____					
Totals:					

Premium Mode:
☒ Monthly ☐ Quarterly
☐ Annually ☐ Semi-Annually

Group#: _____
Employee#: _____

Req Eff Date: ___/___/___ (Mo Day Yr)

Date of Employment: ___/___/___ (Mo Day Yr)

1. Do you now have or have you ever had any other disability coverage with us? ..... Yes ☐ No ☐
   If yes, write the existing Certificate/Policy Number _____.
   Is this application to change☐ or add☐ to this Certificate? ..... Yes ☐ No ☐
2. Is the coverage applied for intended to replace or be in addition to any disability coverage you now have? (If yes, please explain _____) Yes ☐ No ☐
3. Have you ever had a: a) heart attack; b) heart bypass; c) coronary artery disease; d) stroke; e) cancer (other than basal or squamous cell skin cancer); and/or f) test results indicating HIV disease? ..... Yes ☐ No ☐
4. In the last 90 days have you been hospitalized for any reason or been recommended to seek: a) medical advice; b) treatment; c) care; and/or d) counseling that has not yet been performed? ..... Yes ☐ No ☐
5. Are you currently, actively at work on a full time basis and able to perform the duties of your occupation? ..... Yes ☐ No ☐
6. Are you covered by Workers' Compensation? ..... Yes ☐ No ☐

BENEFICIARY

First Name Middle Initial Last Name Relationship to Insured

AUTHORIZATION

I hereby enroll or change, as checked above, for coverages of group insurance for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay. I have decided, after understanding and careful thought, not to take advantage of the other unchecked coverages for which I am eligible. I understand that proof of good health will be required for me if I decide to apply for any available coverage 31 days after the date of eligibility. Such proof will be at my own expense. To the best of my knowledge and belief, the statements and answers shown in this application (front page and, if applicable, the back page) are true and complete. I understand and agree: a) that the Company may rely upon such answers as the basis of my contract; and b) that no coverage will take effect until a Policy or Certificate is issued. I authorize any person or organization having records or knowledge of me or of my health to give Transamerica Assurance Company or its reinsurers such information. Those so authorized include: a) licensed physicians or practitioners; b) hospitals, clinics or medically related facilities; c) Veteran's Administration; d) past or present employers; e) consumer reporting agencies; f) insurance companies or their reinsurers. A photographic copy of this authorization shall be as valid as the original. This authorization will expire two years from the date shown below. I understand that the information collected will be used to determine my eligibility for insurance (this includes information about drugs, alcoholism or mental illness). I understand that: "pre-existing conditions" are generally not covered under the coverage(s) applied for; coverage for maternity benefits may not be provided; and I should read my Certificate for a more detailed explanation of the pre-existing exclusion and maternity coverage, if any. **I understand that other income I am entitled to receive may affect my coverage and I should read my Certificate for more detailed information regarding the affect other income may have on my benefit.**

Completed at _____ this _____ day of _____, _____
(city / state) (month) (year)

Signature of Applicant _____

Signature of Licensed Representative _____ Agent Number: _____

Form TAGC01TN (state)

MEDICAL EVIDENCE OF INSURABILITY

A. Please indicate if applicant has been treated for or diagnosed by a physician or practitioner as having any of the following within the last 10 years: (Circle all applicable condition(s) below.)

1. Adrenal/Pituitary Disorders
2. Acquired Immune Deficiency/ AIDS Related Complex
3. Alcohol Addiction/Abuse
4. Aneurysm/Stroke
5. Asthma/Chronic Bronchitis
6. Arthritis/Gout/Joint Disorder
7. Back Disorder
8. Birth Defects/Congenital Abnormality
9. Blood Disorder/Transfusion/ Hemorrhage
10. Cancer/Leukemia/Hodgkins
11. Circulatory/Vascular Disorder
12. Colitis
13. Complications of Pregnancy
14. Currently Pregnant
15. Diabetes
16. Diagnostic Testing
17. Dizziness/Loss of Consciousness
18. Drug Addiction/Abuse
19. Epilepsy/Seizures/Convulsions
20. Reproductive/Breast Disorders
21. GI Disorder/Ulcer/Crohn's
22. Gonorrhea/Syphillis
23. Headaches
24. Heart Disease, Disorder/Angina
25. High Blood Pressure
26. Immunodeficiency Disorder
27. Kidney/Bladder/Prostate Disorder
28. Liver Disorder/Hepatitis/Cirrhosis
29. Lung Disorder/Respiratory
30. Lupus
31. Lymphatic Disorder
32. Surgery within last 5 years
33. Mental Illness/Emotional Disorder
34. Neurological Disorders/M.S.
35. Pancreatitis
36. Paralysis/Polio Residuals
37. Proctitis/Rectal Disorder
38. Respiratory/Tuberculosis
39. TMJ Disorder
40. Thyroid/Goiter
41. Tumor/Abscess/Cyst
42. Varicose Veins
43. Vision/Hearing Disorders
44. Any Other Health Conditions Not Listed

B. Any Other Medical Treatment Recommended but NOT YET COMPLETED: _____

C. In the spaces below, give details to all conditions circled under A above and indicate dates and condition number(s) of treatment; diagnoses; duration and outcomes. Also list all physicians visits in the last 5 years. Include names and addresses of all attending physicians and medical facilities. If necessary use a separate sheet of paper, dated and signed by you the applicant. Please use the number one space to list the name of the physician who is most likely to have your complete medical records.

Physician's Name and Address	Dates	Condition Number	Results
1.			
2.			
3.			
4.			
5.			

D. I have reviewed all of the above medical conditions and believe my answers to be complete. (Please initial) _____

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

REMARKS

How to calculate the monthly premium

1. Divide your annual salary by 12.
2. Multiply this result by 60% or .60.
3. Round down to the nearest 100.
4. Refer to the rate chart for your premium.

For Example:

If your salary was 32,000, divide by 12, which equals 2666.67 of monthly salary.

Multiply 2666.67 by .60, which equals 1600.01.

Round down to the nearest 100, which equals 1600.

The monthly premium for someone under 55 is $26.08.

Short Term Disability Rate Calculation

14/14 Elimination Period - 3 Month Benefit Period

Monthly Benefit Amount	<55 Years old	55-59	60+
300	$4.89	$6.42	$9.54
400	$6.52	$8.56	$12.72
500	$8.15	$10.70	$15.90
600	$9.78	$12.84	$19.08
700	$11.41	$14.98	$22.26
800	$13.04	$17.12	$25.44
900	$14.67	$19.26	$28.62
1000	$16.30	$21.40	$31.80
1100	$17.93	$23.54	$34.98
1200	$19.56	$25.68	$38.16
1300	$21.19	$27.82	$41.34
1400	$22.82	$29.96	$44.52
1500	$24.45	$32.10	$47.70
1600	$26.08	$34.24	$50.88
1700	$27.71	$36.38	$54.06
1800	$29.34	$38.52	$57.24
1900	$30.97	$40.66	$60.42
2000	$32.60	$42.80	$63.60
All Benefit amounts beyond here requires underwriting unless currently enrolled			
2100	$34.23	$44.94	$66.78
2200	$35.86	$47.08	$69.96
2300	$37.49	$49.22	$73.14
2400	$39.12	$51.36	$76.32
2500	$40.75	$53.50	$79.50
2600	$42.38	$55.64	$82.68
2700	$44.01	$57.78	$85.86
2800	$45.64	$59.92	$89.04
2900	$47.27	$62.06	$92.22
3000	$48.90	$64.20	$95.40
3500	$57.05	$74.90	$111.30
4000	$65.20	$85.60	$127.20
4500	$73.35	$96.30	$143.10
5000	$81.50	$107.00	$159.00
5500	$89.65	$117.70	$174.90
6000	$97.80	$128.40	$190.80

Choose your monthly benefit amount not to exceed 60% of your gross monthly salary
You can choose monthly benefit amounts less than 60%
Any monthly benefit amount greater than $2000 requires medical underwriting
Preexisting conditions apply to anyone not continuously insured by the previous carrier for 12 months
Please see your Plan Administrator for all policy details